



تابع نماذج الهيئة طب العظام

A 34 year old male presented -16 with right knee pain, swelling, redness and fever for 2 days with no history of trauma, sore throat, not other joint involvement, the most appropriate diagnosis is

- a) R.A**
- b) Rh fever**
- c) Septic arthritis**
- d) Gout**

A 30 years old male with hx of -17 pain and swelling of the Rt knee, synovial fluid aspiration showed yellow color opaque appearance, variable viscosity. WBC = 150,000 , 80% neutrophils, poor mucin clot,Dx is

- a. Goutism Arthritis**
- b. Meniscal tear**
- c. RA**
- d. SA (septic arthritis)**
- e. Pseudogout arthritis**

INITIAL ASSESSMENT OF A MUSCULOSKELETAL COMPLAINT

Articular versus nonarticular. Is .1 the pain located in a joint or in a periarticular structure such as soft ?tissue or muscle

**Inflammatory versus .2
noninflammatory. Inflammatory
disease is suggested by local signs
of inflammation (erythema, warmth,
swelling); systemic features
(morning stiffness, fatigue, fever,
weight loss); or laboratory evidence
of inflammation (thrombocytosis,
.elevated ESR or C-reactive protein)
.Acute (≤ 6 weeks) versus chronic .3
.Localized versus systemic .4**

HISTORIC FEATURES

Age, *, race, and family history •
Symptom onset (abrupt or •
indolent), evolution (chronic
constant, intermittent, migratory,
additive), and duration (acute versus
chronic)
Number and distribution of •
involved structures: monarticular
(one joint), oligoarticular (2-3
joints), polyarticular (>3 joints);
symmetry
Other articular features: morning •
stiffness, effect of movement,
features that improve/worsen Sx
(Symptoms)
Extraarticular Sx: e.g., fever, rash, •
weight loss, visual change, dyspnea,
diarrhea, dysuria, numbness,
weakness
Recent events: e.g., trauma, drug •
administration, travel, other
illnesses**

PHYSICAL EXAMINATION

**Complete examination is essential:
particular attention to skin, mucous
membranes, nails (may reveal
characteristic pitting in psoriasis),
eyes. Careful and thorough
examination of involved and**

uninvolved joints and periarticular structures; this should proceed in an organized fashion from head to foot or from extremities inward toward axial skeleton; special attention should be paid to identifying the

:presence or absence of

Warmth and/or erythema .1

Swelling .2

Synovial thickening .3

Subluxation, dis*****, joint .4 deformity

Joint instability .5

Limitations to active and passive .6 range of motion

Crepitus .7

Periarticular changes .8

Muscular changes including .9 weakness, atrophy

LABORATORY INVESTIGATIONS

Additional evaluation usually indicated for monarticular, traumatic, inflammatory, or chronic conditions or for conditions accompanied by neurologic changes .or systemic manifestations

For all evaluations: include CBC, .1 ESR, or C-reactive protein

Where there are suggestive .2 clinical features, include: rheumatoid factor, ANA, antineutrophilic cytoplasmic antibodies (ANCA), antistreptolysin O titer, Lyme antibodies

Where systemic disease is present .3 or suspected: renal/hepatic function tests, UA

Uric acid-useful only when gout .4 diagnosed and therapy contemplated

CPK, aldolase-consider with .5

muscle pain, weakness

Synovial fluid aspiration and .6 analysis: always indicated for acute monarthritis or when infectious or crystal-induced arthropathy is suspected. Should be examined for (1) appearance, viscosity; (2) cell count and differential (suspect septic joint if WBC count > 50,000/ μ L); (3) crystals using polarizing microscope; (4) Gram's stain, cultures

DIAGNOSTIC IMAGING

Conventional radiography using plain x-rays is a valuable tool in the diagnosis and staging of articular disorders

Additional imaging procedures, including ultrasound, radionuclide scintigraphy, CT, and MRI, may be helpful in selected clinical settings

SPECIAL CONSIDERATIONS IN THE ELDERLY PATIENT

The evaluation of joint and musculoskeletal disorders in the elderly pt presents a special challenge given the frequently insidious onset and chronicity of disease in this age group, the confounding effect of other medical conditions, and the increased variability of many diagnostic tests in the geriatric population. Although virtually all musculoskeletal conditions may afflict the elderly, certain disorders are especially frequent. Special attention should be paid to identifying the potential rheumatic consequences of intercurrent medical conditions and therapies

**when evaluating the geriatric pt with
.musculoskeletal complaints**

**A definitive diagnosis of gout is based upon the identification of monosodium urate (MSU) crystals in the synovial fluid.[1] They have a needle-like morphology and strong negative birefringence under polarized light. This test is difficult to perform and often requires a
].trained observer**

**Chondrocalcinosis is a very similar disease, caused by deposition of calcium pyrophosphate rather than
.uric acid**

**fracture of a rib can cause all -18
:except**

- a. Pneumothorax**
- b. Hemothorax**
- c. Esophageal injury midline organ away from fractured rib**
- d. Liver injury**

Osteoporosis with back pain-19

- a. Vitamin D decreased**
- b. Rule out if the X-ray is normal**

.....C

.....e

**yo male has symmetric 27 -20
oligoarthritis , involving knee and elbow , painful oral ulcer for 10
years, came with form of arthritis
:and abdominal pain.Dx is**

- a. Behçet's disease**
- b. SLE**
- c. Reactive arthritis**
- d. UC**
- e. Whipple's disease**

Behçet disease (BD) is characterized

by a triple-symptom complex of recurrent oral aphthous ulcers, genital ulcers, and uveitis

Pertinent site-specific

:manifestations include the following

Skin and mucous membranes •

o Painful oral lesions (aphthous or herpetiform) are one of the criteria for diagnosis and may be the first manifestation (70% of cases)

o Skin lesions often occur in the genital region of both sexes. In males, scrotal involvement is most characteristic; however, lesions can also develop on the penile shaft. In females, the labial area is most commonly involved, with lesions occasionally developing in the vagina and on the perineum. Genital ulcerations typically heal with scarring and are more painful in men

Ocular lesions •

o Ocular presentations (anterior or posterior uveitis, hypopyon, retinal vasculitis) represent the first manifestation of disease in 10% of patients with Behçet disease but usually occur following oral ulceration.¹¹

o Symptoms commonly include blurred vision, periorbital pain, photophobia, scleral injection, and excessive lacrimation

Arthritis •

o Arthritis and arthralgias occur in as many as 60% of patients and primarily affect the lower extremities, especially the knee. Ankles, wrists, and elbows can also be primarily involved

- o The arthritis is nondeforming and asymmetric in nature and can assume a monoarticular, oligoarticular, or polyarticular .pattern of involvement
- o Symptoms relapse and remit and .rarely become chronic
- Gastrointestinal/genitourinary • manifestations
- o GI involvement affects 3-16% of patients with Behçet disease.¹⁷
- o Areas affected often include the .esophagus and ileocecal area
- o Symptoms include abdominal pain, .bloating, and GI bleeding
- o Complications often result from deep ulceration of intestinal .sections
- o GU involvement can include epididymitis, neurogenic bladder, .and sterile urethritis

Reactive arthritis (ReA), also known as Reiter syndrome, is an autoimmune condition that develops in response to an infection. In 1916, Hans Reiter described the triad of nongonococcal urethritis, conjunctivitis, and arthritis in a young German officer with bloody dysentery.¹ In 1916, Fiessinger and Leroy described 4 patients with what they called oculo-urethro-synovial syndrome and associated the syndrome with an outbreak of .Shigella dysentery

Systemic lupus erythematosus (SLE) is a chronic, multifaceted inflammatory disease that can affect every organ system of the body. SLE is protean in its manifestations and follows a relapsing and remitting course. This article addresses what

is known regarding the etiology, pathophysiology, clinical features, and treatment of SLE

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease that can affect almost any organ system. Its presentation and course are highly variable, ranging from indolent to fulminant. The following is an overview of the multitudinous protean manifestations.^{15,16}

Constitutional symptoms: •

Nonspecific fatigue, fever, arthralgia, and weight changes are the most common symptoms in new cases or recurrent active SLE flares. Fatigue, the most common constitutional symptom associated with SLE, can be due to active SLE, medications, lifestyle habits, or concomitant fibromyalgia or affective disorders. Fatigue due to active SLE generally occurs in concert with other clinical and laboratory markers. Fever, another common yet nonspecific symptom of SLE, may also result from many causes, the most common of which include active SLE, infection, and drug fever. Careful history taking may help to differentiate these. Weight loss may occur in patients with active SLE. Weight gain may also be due to corticosteroid treatment or active disease such as nephrotic syndrome anasarca

Musculoskeletal symptoms: Joint •

pain is one of the most common reasons for the initial clinical presentation in patients with SLE. Arthralgia, myalgia, and frank arthritis may involve the small joints of the hands, wrists, and knees. In

contrast to rheumatoid arthritis, SLE arthritis or arthralgia may be asymmetrical, with pain that is

.disproportionate to swelling

Dermatological symptoms •

o Cutaneous manifestations of SLE comprise 4 diagnostic criteria and multiple other clues to a potential

.diagnosis of lupus

The first is malar rash, which is characterized by an♣ erythematous rash over the cheeks and nasal bridge. It lasts from days to weeks and is occasionally painful or

.pruritic

The second feature is♣ photosensitivity, which may be elicited from patients who are asked if they have any unusual rash or symptom exacerbation after sun

.exposure

The third♣ feature may be discoid rash. Discoid lesions often also develop in sun-exposed areas but are plaquelike in character, with follicular plugging and scarring. They may be part of systemic lupus or may represent discoid lupus without organ involvement, which is a

.separate diagnostic entity

Alopecia is the fourth♣ and often less-specific cutaneous feature of SLE. It often affects the temporal regions or creates a patchlike

.pattern of hair loss

o Other cutaneous manifestations related to but not specific to SLE include Raynaud phenomenon, livedo reticularis, panniculitis (lupus profundus), bullous lesions, vasculitic purpura, telangiectasias, .and urticaria

Renal features: The kidney is the •

most commonly involved visceral organ in SLE. Although only approximately 50% of patients with SLE develop clinically evident renal disease, biopsy studies demonstrate some degree of renal involvement in almost all patients. Glomerular disease usually develops within the first few years of SLE onset and is usually asymptomatic. Acute or chronic renal failure may cause symptoms related to uremia and fluid overload. Acute nephritic disease may manifest as hypertension and hematuria. Nephrotic syndrome may cause edema, weight gain, or hyperlipidemia

yo fell on outstretched 70 -21
hand .on examination: intact radial
and ulnar pulses, dinner fork
deformity .Tender radial head.
:Diagnosis is
.Colles fracture-
Fracture of distal ulna & -
displacement of radial head
Fracture of scaphoid-
fracture of shaft of radius with -
.displacement of head of ulna

An 80 year old lady presented to -22
your office with a 6 month history of
stiffness in her hand,bilaterally. This
stiffness gets worse in the morning
and quickly subsides as the patient
begins ge daily activities. She has no
other significant medical problems.
On examination the patient has
bilateral bony swellings at the
margins of the distal interphalangeal
joints on the (2m15th) digits. No
other abnonnalities were found on

**the physical examination. These
:swellings represent**

- A) Heberden's nodes**
- B) Bouchard's nodes**
- C) Synovial thickenings**
- D) Subcutaneous nodules**
- E) Sesamoids**

**a 25 year old male who recently -23
came from India presented with a 3
days history of left knee pain +
swelling, 1 day history of right wrist
swelling.on examination it was
swollen, tender,red with limitation of
movement50 cc of fluid was
aspirated from the knee.Gram
stained showed gram positive
diplococci.Whats the most likely
?organism**

- a) brucella**
- b) nisseria meningitides**
- ??c) strep. Pneumonia**
- d) staph aureus**
- e) strept. pyogens**

**What is the simplest method to -24
:diagnose fractured rib**

- a) Posteroanterior x ray simple but
less sensitive (50%)**
- b) Lateral x ray**
- c) Tomography of chest more
sensitive but not simple**

**Chest radiographs •
o Anteroposterior (AP) and lateral
chest films are used routinely to
assist in the diagnosis of rib
fractures, yet sensitivity as low as
50% has been reported. Delayed or
follow-up radiographs can be very
.helpful
o Chest radiographs are much more
useful in the diagnosis of underlying
injuries, including hemothorax,**

pneumothorax, lung contusion, atelectasis, pneumonia, and vascular injuries

Rib radiographs •

- o Obtaining a rib radiograph series remains controversial, as the additional information rarely changes the clinical picture or alters treatment. This rib detail radiographs can be helpful in evaluation of the 1st and 2nd ribs and the 7th through 12th ribs. Formal plain radiographs can also be useful to ***** abuse for legal purposes

- o Diagnostic sensitivity is higher in rib radiographs than in chest radiographs; however, with a high clinical suspicion, treat for fracture regardless of the radiographic result. A rib radiograph is shown below

Chest CT scan •

- o A chest CT scan is more sensitive than plain radiographs for detecting rib fractures. The modality can also provide information regarding the number of ribs involved

- o If complications from rib fractures is suspected clinically or diagnosed by plain radiographs, a chest CT scan may be helpful to ***** specific injuries, characterize extent of injury, and plan for definitive management

- o An associated CT scan of the abdomen with intravenous contrast should be considered in cases involving lower rib fractures with suspected or known injury to the liver and/or the spleen

Angiography •

- o Since first and second rib fractures

are often associated with vascular injury, ED physicians should consider angiography for such patients, especially if symptoms and signs of neurovascular compromise are

.present

o This is particularly important with posteriorly displaced fractures of the first 2 ribs, which have a much higher degree of association with abnormal angiographic findings than

.other rib fractures

o While first rib fractures previously were considered a strong risk factor for aortic injury, most authorities now believe that aortography and/or CT scan are not indicated without other evidence of injury, such as

.abnormal mediastinum

A 30-year-old man had pelvic -25 fracture due to blunt trauma. Retrograde urethrography demonstrated disruption of the membranous urethra. The best initial :treatment is

.A. Passage of transurethral catheter

.B. Suprapubic catheter

.C. Perineal repair

.D. Retropubic repair

.E. Transabdominal repair

Pelvic fracture is a disruption of the bony structures of the pelvis. In elderly persons, the most common cause is a fall from a standing position. However, fractures associated with the greatest morbidity and mortality involve significant forces such as from a motor vehicle crash or fall from a

.height

**Do not place a urinary catheter •
until urethral injury has been ruled
out or determined to be unlikely by
physical examination or retrograde
.urethrography**

**The traditional intervention for •
men with posterior urethral injury
secondary to pelvic fracture is
placement of a suprapubic catheter
for bladder drainage and subsequent
delayed repair. This is the safest
approach because it establishes
urinary drainage and does not
require either urethral manipulation
or entrance into the hematoma
.caused by the fracture of the pelvis**

fractured humerus commonly -26

:associated with

a) radial N injury

b) ulnar N injury

c) medial N injury

d) axillary N injury

e) musculocutaneous N injury

**Perform a careful neurovascular
examination. Radial nerve injury
following humerus shaft fractures is
.relatively common**

Assessment of the radial nerve •

**o The radial nerve's primary motor
function is to innervate the dorsal
extrinsic muscles in the forearm.**

**Motor testing should include
extension of the wrist and**

******carpophalangeal (MCP) joints as
well as abduction and extension of
the thumb. Proximal injury of the**

.radial nerve causes wrist drop

**o On examination, the fingers are in
flexion at the MCP joints and the
.thumb is adducted**

- Rarely, the median or ulnar nerves are affected
- With all humerus fractures, ensure strong radial and ulnar pulses

fractured pelvis commonly -27
:associated with

- a) bladder injury
- b) penile urethra injury
- c) bulbomembraneus urethra injury
- d) ureter injury

Posterior urethral injuries are located in the membranous and prostatic urethra. These injuries are most commonly related to major blunt trauma such as motor vehicle collisions and major falls, and most of such cases are accompanied by pelvic fractures

Complications of pelvic fracture include the following

- Increased incidence of deep venous thrombosis
- Continued bleeding from fracture or injury to pelvic vasculature
- GU problems from bladder, urethral, prostate, or vaginal injuries: The incidence of urethral injuries varies by the type of pelvic fracture. Straddle fractures associated with sacroiliac diastasis have the highest incidence (odds ratio of 24). Without diastasis, the odds ratio dropped to 3.85. Urethral injuries are uncommon in patients with fractures not involving the

.ischiopubic rami
ual dysfunction may develop*** •
Infections from disruption of bowel •
or urinary system
Chronic pelvic pain •

Patient with RT femur fracture -28
developed chest pain, hemoptysis,
ABG Po₂ below 65 pCO₂ increased,
:first line of management
a) Heparin. For pulmonary embolism
after DVT or fat embolism
.b) aminophylline

:Complications of femur fracture
Hemorrhagic shock •
o Closed fractures of the femur can
result in significant blood loss (eg, 1
L) within the thigh. Open fractures
have the potential for even greater
.blood loss
o Because of the high rate of
associated injuries, actively seek out
other sources of blood loss in
patients with femur fractures and
.hypovolemic shock
Neurovascular injury •
o Injuries to the neurovascular
bundle are rare because of the large
cushion of muscle protecting
.neurovascular structures
o Compartment syndrome of the
thigh does not occur often, and
peroneal nerve contusion is seen
.occasionally
Infection: While open fractures are •
at high risk of soft-tissue and bony
infection, postoperative infection is
rare following repair of closed
.fractures
Respiratory demise: Fat embolism •
and adult respiratory distress
.syndrome (ARDS) can occur

More delayed complications •
include permanent stiffness of the
hip or knee, shortening of the
extremity, or malrotation, resulting
in permanent deformity and
.decreased performance
Complications directly related to •
repair include (in order of increasing
frequency) breakage of fixator
hardware, nonunion, malunion, or
.delayed union
Finally, refracture has occurred at •
.the initial injury site

which of the following is not true -29
:regarding osteomyelitis
a)pyomyositis
b)epiphyseal plate destruction
c)septic arthritis(it can develop due
to septic arthritis)
d)septicemia
e)after bone growth

Which one of the following -
regarding osteomyelitis
Pyomyositis (1
Epiphyseal plate destruction (2
Septicemia (3
Septic arthritis (4

Osteomyelitis is an acute or chronic
inflammatory process of the bone
and its structures secondary to
infection with pyogenic
organisms.The infection associated
with osteomyelitis may be localized
or it may spread through the
periosteum, cortex, marrow, and
cancellous tissue. The bacterial

pathogen varies on the basis of the patient's age and the mechanism of .infection

The following are the 2 primary categories of acute osteomyelitis: hematogenous osteomyelitis and direct or contiguous inoculation .osteomyelitis

Hematogenous osteomyelitis is an .1 infection caused by bacterial seeding from the blood. Acute hematogenous osteomyelitis is characterized by an acute infection of the bone caused by the seeding of the bacteria within the bone from a remote source. This condition primarily occurs in children. The most common site is the rapidly growing and highly vascular **physis of growing bones. The apparent slowing or sludging of blood flow as the vessels make sharp angles at the distal ****physis predisposes the vessels to thrombosis and the bone itself to localized necrosis and bacterial seeding. Acute hematogenous osteomyelitis, despite its name, may have a slow clinical development and .insidious onset**

Direct or contiguous inoculation .2 osteomyelitis is caused by direct contact of the tissue and bacteria during trauma or surgery. Direct inoculation (contiguous-focus) osteomyelitis is an infection in the bone secondary to the inoculation of organisms from direct trauma, spread from a contiguous focus of infection, or sepsis after a surgical procedure. Clinical manifestations of direct inoculation osteomyelitis are

more localized than those of
hematogenous osteomyelitis and
.tend to involve multiple organisms

Additional categories include chronic
osteomyelitis and osteomyelitis
secondary to peripheral vascular
.disease

Chronic osteomyelitis persists or •
recurs, regardless of its initial cause
and/or mechanism and despite
.aggressive intervention

Although listed as an etiology, •
peripheral vascular disease is
actually a predisposing factor rather
.than a true cause of infection

Disease states known to predispose
: patients to osteomyelitis include
diabetes mellitus,1 .1
,sickle cell disease .2
acquired immune deficiency .3
,syndrome (AIDS)
,intravenous (IV) drug abuse .4
,alcoholism .5
,chronic steroid use .6
immunosuppression, and .7
.chronic joint disease .8

In addition, the presence of a .9
prosthetic orthopedic device is an
independent risk factor, as is any
recent orthopedic surgery or open
.fracture

Male-to-female ratio is
.approximately 2:1

Age

In general, osteomyelitis has a
bimodal age distribution. Acute
hematogenous osteomyelitis is
primarily a disease in children.
Direct trauma and contiguous focus

osteomyelitis are more common among adults and adolescents than in children. Spinal osteomyelitis is more common in persons older than .45 years

Clinical

History

Hematogenous osteomyelitis usually presents with a slow insidious progression of symptoms. Direct osteomyelitis generally is more localized, with prominent signs and .symptoms

General symptoms of osteomyelitis :include the following

Hematogenous long-bone • osteomyelitis

Abrupt onset of high fever (fever .1 is present in only 50% of neonates with osteomyelitis)

Fatigue .2

Irritability .3

Malaise .4

Restriction of movement .5 (pseudoparalysis of limb in neonates)

Local edema, erythema, and .6 tenderness

Hematogenous vertebral • osteomyelitis

Insidious onset .1

History of an acute bacteremic .2 episode

May be associated with .3 contiguous vascular insufficiency

Local edema, erythema, and .4 tenderness

Failure of a young child to sit up .5 normally³

Chronic osteomyelitis •

Nonhealing ulcer .1

Sinus tract drainage .2
Chronic fatigue .3
Malaise .4
Physical
Findings at physical examination
:may include the following
Fever (present in only 50% of .1
neonates)
Edema .2
Warmth .3
Fluctuance .4
Tenderness to palpation .5
Reduction in the use of the .6
extremity (eg, reluctance to
ambulate, if the lower extremity is
involved or pseudoparalysis of limb
in neonates)
Failure of a young child to sit up .7
normally
Sinus tract drainage (usually a .8
late finding or one that occurs with
chronic infection)

Causes

Note that responsible pathogens
may be isolated in only 35-40% of
infections. Bacterial causes of acute
and direct osteomyelitis include the
:following

Acute hematogenous osteomyelitis
(Note increasing reports of other
pathogens in bone and joint
infections including community-
associated methicillin-resistant
Staphylococcus aureus [MRSA],⁴
Kingella kingae,⁵ and others.)

Newborns (younger than 4 mo): *S* .1
aureus, *Enterobacter* species, and
group A and B *Streptococcus* species

Children (aged 4 mo to 4 y): *S* .2
aureus, group A *Streptococcus*

species, *Haemophilus influenzae*,
and *Enterobacter* species
Children, adolescents (aged 4 y to .3
adult): *S aureus* (80%), group A
Streptococcus species, *H influenzae*,
and *Enterobacter* species
Adult - *S aureus* and occasionally .4
Enterobacter or *Streptococcus*
species

Direct osteomyelitis
General - *S aureus*, *Enterobacter* .1
species, and *Pseudomonas* species
Puncture wound through an .2
athletic shoe - *S aureus* and
Pseudomonas species
Sickle cell disease - *S aureus* and .3
Salmonellae species

Radiographic evidence of acute •
osteomyelitis is first suggested by
overlying soft-tissue edema at 3-5
.days after infection
o Bony changes are not evident for
14-21 days and initially manifest as
periosteal elevation followed by
cortical or medullary lucencies. By
28 days, 90% of patients
.demonstrate some abnormality
o Approximately 40-50% focal bone
loss is necessary to cause detectable
.lucency on plain films
MRI •
o The MRI is effective in the early
detection and surgical localization of
osteomyelitis.6,7
o Studies have shown its superiority
compared with plain radiography,
CT, and radionuclide scanning in
.selected anatomic *****s
.o Sensitivity ranges from 90-100%

The primary treatment for

osteomyelitis is parenteral antibiotics that penetrate bone and joint cavities. Treatment is required for at least 4-6 weeks. After intravenous antibiotics are initiated on an inpatient basis, therapy may be continued with intravenous or oral antibiotics, depending on the type and ***** of the infection, on .an outpatient basis

The following are recommendations for the initiation of empiric antibiotic treatment based on the age of the :patient and mechanism of infection

With hematogenous osteomyelitis • (newborn to adult), the infectious agents include *S aureus*, Enterobacteriaceae organisms, group A and B *Streptococcus* species, and *H influenzae*. Primary treatment is a combination of penicillinase-resistant synthetic penicillin and a third-generation cephalosporin. Alternate therapy is vancomycin or clindamycin and a third-generation cephalosporin, particularly if methicillin-resistant *S aureus* (MRSA) is considered likely. Linezolid is also used in these circumstances. In addition to these above-mentioned antibacterials, ciprofloxacin and rifampin may be an appropriate combination therapy for adult patients. If evidence of infection with gram-negative bacilli is observed, include a third- .generation cephalosporin

In patients with sickle cell anemia • and osteomyelitis, the primary bacterial causes are *S aureus* and *Salmonellae* species. Thus, the primary choice for treatment is a fluoroquinolone antibiotic (not in

children). A third-generation cephalosporin (eg, ceftriaxone) is an alternative choice

When a nail puncture occurs • through an athletic shoe, the infecting agents may include *S aureus* and *Pseudomonas aeruginosa*. The primary antibiotics in this scenario include ceftazidime or cefepime. Ciprofloxacin is an alternative treatment

For patients with osteomyelitis due • to trauma, the infecting agents include *S aureus*, coliform bacilli, and *Pseudomonas aeruginosa*. Primary antibiotics include nafcillin and ciprofloxacin. Alternatives include vancomycin and a third-generation cephalosporin with antipseudomonal activity

Complications of osteomyelitis may include the following

- Bone abscess •
 - Bacteremia •
 - Fracture •
 - Loosening of the prosthetic • implant
 - Overlying soft-tissue cellulitis •
 - Draining soft-tissue sinus tracts •
- Prognosis

The prognosis varies but is • markedly improved with timely diagnosis and aggressive therapeutic intervention

All of the following muscles are -30 :rotator cuff except

- a) supra-spinatus
- b) teres minor
- c) infraspinatus
- d) deltoid

All of the following muscles are -

: part of rotator cuff, except

- .a) supra-spinatus**
- .b) Infra-spinatus**
- .c) Deltoid**
- .d) Subscapularis**
- .e) Teres minor**

The rotator cuff muscles are the supraspinatus, infraspinatus, subscapularis, and teres minor

Rotator cuff injuries are problems commonly encountered in athletic and nonathletic patients. Symptoms include pain, weakness, and decreased range of motion. Early diagnosis is important for identifying causes, implementing effective treatment, and preventing further injury

Pain is the most common symptom encountered with rotator cuff injury. Following pain, weakness and limitation of motion are the next most common symptoms of a rotator cuff tear

The patient also may complain of clicking, catching, stiffness, and crepitus

Avascular necrosis of the head of -31 femur is usually detected clinically

:by

- .a) 3 months**
- .b) 6 months**
- .c) 11 months**
- d) 15 months**
- e) 9months**

AVN” avascular necrosis of “ - femoral head becomes evident

:clinically in

- a) 3 months**

- b) 6 months**
- c) 9 months**
- d) 12 months**
- e) 17 months**

Avascular necrosis of head of femur - usually detected clinically by the age of

- months 3 .1**
- months 6 .2**
- months 11 .3**
- months 15 .4**

Avascular necrosis (AVN) is defined as cellular death of bone components due to interruption of the blood supply; the bone structures then collapse, resulting in bone destruction, pain, and loss of joint function. AVN is associated with numerous conditions and usually involves the epiphysis of long bones, such as the femoral and humeral heads and the femoral condyles, but small bones can also be affected. In clinical practice, AVN is most commonly encountered in the hip. Recently, AVN of the jaw associated with bisphosphonate use has also been described.¹

Early diagnosis and appropriate intervention can delay the need for joint replacement. However, most patients present late in the disease course. Without treatment, the process is almost always progressive, leading to joint destruction within 5 years. Patients taking corticosteroids and organ transplant recipients are particularly at risk of developing AVN. Most available data regarding the natural history, pathology, pathogenesis,

and treatment of AVN pertains to
.femoral head necrosis
Avascular necrosis has no
distinguishing clinical features.
Patients do not experience pain
during the ischemic episode. Occult
AVN can be present for more than 5
years before the onset of symptoms.
Patients may be asymptomatic or
may develop pain gradually and
insidiously; they may experience a
decrease in range of motion (ROM)
and may walk with a limp. Pain may
be excruciating and of sudden onset,
with the patient able to note the
.exact time and date it began

Supra-condylar fracture pt -32
presented with swelling and
cyanosis of finger after plaster
:Management
a) Removal of splint near finger
b) Entire removal of all splint

in affected index finger, all can -33
: be used, except
a) rubber tourniquet
b) xylocaine
c) adrenaline
d) ring block

Patient presented with fluctuant -34
:redness of finger bulb. Treatment
a) Incision
b) Penicillin

Congenital dis***** of hip; all -35
: are true except
a) More in girls
b) Best examined after 12-36 hours
from birth after birth immediately

- with neonatal examination
- c) There will be limitation in abduction of thigh
- d) Barlow test will give click indicating CDH
- e) Can be treated by splint

The term congenital dis***** of the hip dates back to the time of Hippocrates. This condition, also known as hip dysplasia or developmental dysplasia of the hip (DDH), has been diagnosed and treated for several hundred years. Most notably, Ortolani, an Italian pediatrician in the early 1900s, evaluated, diagnosed, and began treating hip dysplasia. Galeazzi later reviewed more than 12,000 cases of DDH and reported the association between apparent shortening of the flexed femur and hip dis*****.

Since then, significant progress has been made in the evaluation and treatment of DDH (see image below).1,2,3,4

This condition may occur at any time, from conception to skeletal maturity. The author prefers to use the term hip dysplasia because he believes this term is simpler and more accurate. Internationally, this disorder is still referred to as .congenital dis***** of the hip

More specific terms are often used to better describe the condition; :these are defined as follows

Subluxation - This is incomplete • contact between the articular surfaces of the femoral head and .acetabulum

Dis***** - This refers to •

complete loss of contact between the articular surface of the femoral head and acetabulum

Instability - This consists of the • ability to subluxate or dislocate the hip with passive manipulation

Teratologic dis***** - This refers • to antenatal dis***** of the hip
Frequency

The overall frequency of developmental dysplasia of the hip (DDH) is usually reported as approximately 1 case per 1000 individuals, although Barlow believed that the incidence of hip instability during newborn examinations was as high as 1 case per 60 newborns.⁵ According to his study, more than 60% of hip instability became stable by age 1 week, and 88% became stable by age 2 months, leaving only 12% (of the 1 in 60 newborns, or 0.2%) with residual hip instability.⁵

Presentation

Early clinical manifestations of developmental dysplasia of the hip (DDH) are identified during examination of the newborn. The classic examination finding is revealed with the Ortolani maneuver; a palpable "clunk" is present when the hip is reduced in and out of the acetabulum and over the neolimbus. A high-pitched "click" (as opposed to a clunk) in all likelihood has little association with acetabular pathology.^{22,23} Ortolani originally described this clunk as occurring with either subluxation or reduction of the hip (in or out of the acetabulum). More commonly, the Ortolani sign is referred to as a

clunk, felt when the hip reduces into the acetabulum, with the hip in abduction

To perform this maneuver correctly, the patient must be relaxed. Only one hip is examined at a time. The examiner's thumb is placed over the patient's inner thigh, and the index finger is gently placed over the greater trochanter. The hip is abducted, and gentle pressure is placed over the greater trochanter. In the presence of DDH, a clunk, similar to turning a light switch on or off, is felt when the hip is reduced. The Ortolani maneuver should be performed gently, such that the fingertips do not blanch.²⁴

Barlow described another test for DDH that is performed with the hips in an adducted position, in which slight gentle posterior pressure is applied to the hips. A clunk should be felt as the hip subluxes out of the acetabulum.⁵

The clinical examination for late DDH, when the child is aged 3-6 months, is quite different. At this point, the hip, if dislocated, is often dislocated in a fixed position.¹¹ The Galeazzi sign is a classic identifying sign for unilateral hip dis***** (see image below). This is performed with the patient lying supine and the hips and knees flexed. The examination should demonstrate that one leg appears shorter than the other. Although this finding is usually due to hip dis*****, realizing that any limb-length discrepancy results in a positive

.Galeazzi sign is important
Indications for treatment depend on the patient's age and the success of the previous techniques. Children younger than 6 months with instability upon examination are treated with a form of bracing, usually a Pavlik harness. If this is not effective or if the hip instability or dis*** is noted when the child is older than 6 months, closed reduction is typically recommended, often with the administration of .traction before the reduction**

When the child is older than 2 years or with failure of the previous treatment, open reduction is considered. If the patient is older than 3 years, femoral shortening is performed instead of traction, with additional varus applied to the femur, if necessary. A patient with residual acetabular dysplasia who is older than 4 years should be treated .with an acetabular procedure

A 2-year-old baby was brought to -37 the clinic because of inability to walk straight. On examination, there was asymmetry of skin creases in the groin. The Trendelenburg's sign was positive on the left side. Your :diagnosis is

- .A. Fracture pelvis**
- .*****B. Congenital hip dis**
- .C. Fracture femur on the left side**
- .D. Poliomyelitis**
- .E. Rickets**

congenital hip dis*** (CHD) -39**

- a) Dx after 3 yrs**
- b) abduction + flexion (ortolani test)**

- produce click
- c) abduction not limited
- d) lengthening of the leg
- e) rx by open reduction

Concerning green stick fracture -31

:in children, all are true except

- a- Extremely painful
- b- Most commonly involve the forearm
- c- Function of the limb is preserved
- d- Is incomplete fracture

تابع.....



التوقيع - محمد pp

ما في المقام لذي
عقل وذي أدب من
راحة فدع الأوطان
واغترب
سافر تجد
عوضا عما تفارقه
واكدح فإن لذيد
العيش في النصب
إني رأيت وقوف
الماء يفــــسده
إن سار طاب وإن لم
يسر لم يطلب
والأسد لولا فراق
الغاب ما افترست
والسهم لولا فراق
القوس لم يصب
والشمس لو وقفت
في الفلك دائمة

لملها الناس من عجم ومن عرب

التعديل الأخير تم بواسطة محمد03-02-2012 الساعة 10:41 AM .

اقتباس



محمدpp

مشاهدة ملفه الشخصي

إرسال رسالة خاصة إلى محمدpp

البحث عن المشاركات التي كتبها محمدpp

AM 10:12 ,03-02-2012



محمدpp

Master

member



تابع نماذج طب العظام

مجموعة الاسئلة القادمة لكم من كتاب المعادلة الام 2010 والحلول بعد الاسئلة

الآخر [LEFT]

A 20-year old male was skateboarding and fell off while attempting to jump a flight of stairs. He lands with his upper arm against the edge of a step and hears a crack. At the hospital he is told that he has suffered a fracture of the left humeral shaft. What nerve and artery are at risk in this type of injury?

- a) Ulnar nerve and axillary artery
- b) Axial nerve and radial artery
- c) Median nerve and brachial artery
- d) Radial nerve and brachial artery
- e) Musculocutaneous nerve and axillary artery
- f) Anterior interosseous nerve and dorsal scapular artery

27-year old male is playing soccer on a (2) grassy field when he is tackled from the back. He immediately grabs his lower right leg and to his horror feels a bone protruding through the skin. At the hospital he is diagnosed with an open fracture of the right tibia. Which of the following initial antibiotic regimens is appropriate

a) Cefazolin for 24 hours

b) Cefazolin for 48 hours

c) Cefazolin, gentamicin and penicillin for 48 hours

d) Cefazolin and gentamicin for 48 hours

e) Gentamicin for 48 hours

33-year old female is picking apples from (3) an apple tree when she slips and falls from a height of 14 feet, landing on her feet. Her right ankle is very sore after the injury so she proceeds to the local emergency room. According to the Ottawa Ankle Rules, which of the following would be an indication for an x-ray imaging of the affected ankle

a) Inability to weight bear immediately after the injury

b) Inability to weight bear immediately after the injury and pain in the malleolar zone

c) Pain in the malleolar zone and bony tenderness over the posterior aspect of the lateral malleolus

d) Bony tenderness over the posterior aspect of the medial malleolus

e) Bony tenderness over the anterior aspect of the medial malleolus

44-year old male is involved in a multiple (4) vehicle collision during morning rush hour. Arriving to the hospital via ambulance around noon, it is discovered that the gentleman is suffering, among a variety of minor injuries, from an open fracture of the left distal radius. Upon questioning, it is revealed that this gentleman is quite healthy and taking no medications. He

denies any allergies. On physical examination open fracture is quite obvious, although laceration is <2cm. A neurovascular examination is unremarkable for any worrisome findings. At this point, the most important first step in management would be to immobilize in a cast and follow-up in 1 week to reassess healing. Do not proceed straight to the OR for an I and D, followed by ORIF.

Inquire about tetanus status and respond accordingly. Administer antibiotics that target gram negative and anaerobic bacteria. Inquire about tetanus, give antibiotics and book the patient for an intraoperative I and D, and possible ORIF, to be done the following day.

Orthopedics

You are the on call orthopedic surgery (5) resident during a stormy winter night during the evening hours, you are paged to see a 73 year old lady who slipped on a patch of black ice. She is complaining of severe right hip pain and nothing else. After questioning, you find out she suffers from hypertension and osteoporosis. However, you also discover that she has broken her right distal radius on 2 other occasions - fixed with closed reduction on both occasions. Her osteoporosis is being managed with calcium, vitamin D and an oral bisphosphonate. Her antihypertensive medication is unknown, but she admits that her blood pressure is well controlled. There are no other medications. Her history also reveals that she has had an appendectomy and C-section in the past, has no allergies, has never smoked and her last meal was lunch time. On physical examination, her right leg is shortened and in marked external rotation.

her right leg, as well as her other
remities, are neurovascularly intact
rest of the exam is unremarkable. You
d this lovely lady for an X-ray which
s a grade 4 subcapital fracture of her
t hip. Her intraoperative treatment
:would include

- Hemiarthroplasty of her right hip
- Total arthroplasty of her right hip
- c) Dynamic hip screw
- d) Gamma nail
- e) ORIF femoral neck

ear old male suffers an undisplaced (6
cture of his medial malleolus. It is
obilized with a plaster cast. He has a
ow up visit in the fracture clinic in 2
ks time to assess bone healing. You
n to him the potential complications of
racture, including all of the following

:EXCEPT

- a) Mal-union
- b) Non-union
- c) Infection
- d) Fat embolism
- e) DVT

year-old motorcyclist presents in the (7
mergency department following an
ident. He has a compound tibia and
ula fracture of the right leg and on
mination the right leg has no pulses
our immediate treatment should be

- a) Immediate angiogram
- b) Immediate surgery
- c) Casting and/or splinting
- d) Reduction and splinting
- e) X-ray

of the following is the most serious (8
lication of a displaced supracondylar
?fracture of the humerus

- mpartment syndrome of the forearm
- b) Failure to heal
- healing in a non-anatomical position

d) Injury to the median nerve
Significantly limited range of elbow motion

the following statements regarding (9
knee injuries are correct EXCEPT
locking of the knee may be due to a
torn meniscus

Minor tears of the medial collateral
ligament can be treated with brief
immobilization then range of motion and
strengthening exercises

) Lateral meniscus tears are more
common than medial meniscal tears
Anterior cruciate ligament tears may
give a positive Lachman test

A knee dis*** may be associated**
with major ligament damage
70-year-old man has fallen while walking (10
down stairs. He is brought to the
emergency department with a 3-part
trochanteric hip fracture. Which of the
following procedures would you choose to
?perform

- a) Hemiarthroplasty**
- b) Total hip replacement**
- c) Multiple pin fixation**
- d) Bipolar arthroplasty**
- e) Pin and plate**

70-year-old female fell while roller-blading (11
her outstretched right hand. At a nearby
emergency department X-rays confirmed
diagnosis of a closed Colles fracture
proper reduction technique for this
fracture is which of the following
right extension, full pronation, and full
ulnar deviation

right flexion, full supination, and full
radial deviation
right extension, full supination, and full
ulnar deviation
right flexion, full pronation, and full
ulnar deviation

ght extension, full pronation, and full
radial deviation

n of the following is least likely to (12

:cause avascular necrosis

- a) Sickle cell disease
- b) Septic arthritis
- c) Steroid use
- d) Constrictive dressings
- e) Post-traumatic fracture

year-old football player severely (13
ures his ankle while playing in a game
subsequently requires ORIF treatment
ations for ORIF treatment of an ankle
acture include all of the following

:EXCEPT

*****a) A fracture-dis
displaced fracture with Grade II ATFL
tear

c) Trimalleolar fracture
d) Unstable talar tilt
nable to maintain a closed reduction
the following radiographic features is (14
consistent with osteoarthritis of the
?knee

a) Marginal erosions
b) Juxta-articular osteopenia
(demineralization)
of articular cartilage with narrowing of
the radiologic joint space
steonecrosis (avascular necrosis) of
the medial femoral condyle
e) Syndesmophyte formation

he following have been associated (15

*****with posterior shoulder dis
:EXCEPT

a) Ethanol
b) Electricity
c) Exercise
d) Epilepsy
e) Encephalitis

gement of an open fracture should (16
ways include each of the following

:EXCEPT

- Assessment of neurovascular status
- Reduction and fixation of fracture
- Irrigation and debridement of wound
- d) Application of sterile dressing
- e) Application of topical antibiotics

ANSWERS

- D .1
- C .2
- C .3
- C .4
- B .5
- D .6
- D .7
- A .8
- C .9
- E .10
- D .11
- D .12
- B .13
- C .14
- C .15
- E[/LEFT .16

تابع

■ ■ ■ ■ ■



التوقيع - محمد pp

ما في المقام لذي عقل
وذي أدب من راحة فدع
الأوطان واغترب
سافر تجد عوضا عما
تفارقه واكدح فإن لذيذ العيش
في النصب

إني رأيت وقوف الماء
يفسده إن سار طاب
وإن لم يسر لم يطلب
والأسد لولا فراق الغاب ما
افترست والسهم لولا فراق
القوس لم يصب
والشمس لو وقفت في الفلك
دائمة لملها الناس من
عجم ومن عرب

AM 10:39 التعديل الأخير تم بواسطة محمد2012-02-03 ; الساعة 10:39 AM



محمدpp
مشاهدة ملفه الشخصي
إرسال رسالة خاصة إلى محمدpp
البحث عن المشاركات التي كتبها محمدpp

رقم المشاركة : 7

AM 10:17 ,03-02-2012



محمدpp

Master

member



تابع نماذج امتحانات العظام

نيجي لاهم جزء اللي فيه
40% من الاسئلة ككل
وهو ال trauma

A 20 year old man involved in a -1
RTA (Road traffic accident) brought
to ER by friends. On examination he
was found to be conscious but
drowsy .Vitals: HR 120 beats/min, BP
80/40 the most urgent initial
management measure is
A) CT scan of brain
B) X-RAY of cervical spine
C) Rapid infusion of crystalloid ABC
D) ECG to exclude heamopericardium

E) U.S abdomen

A 30 year old man presents with -2 shortness of breath after a blunt injury to his chest,RR 30 breaths/min,CXR showed complete collapse of the left lung with pneumothorax, mediastinum was shifted to the right. The treatment of :choice is

- A) Chest tube insertion**
- B) Chest aspiration**
- C) Thorocotomy and pleurectomy**
- D)IV fluids & O2 by mask**
- E) Intubation**

in a conscious multiple trauma -3 :patient your priorities are
a)to stop bleeding,then IV fluids
b)to secure air entry,breathing then BP
c)to start an iv fluid and send blood for cross matching
d)to intubate the patient
e)to do peritoneal lavage then IV fluids

Conscious with multiple trauma - :patient. Your priority is
a-intubate the patient
.b-peritoneal lavage then insert IV
.c-assess airway, breathing & BP
d-insert IV line then send blood for .matching

Pt conscious with multiple trauma, - :first step in management
Assess airway •
Iv line •
Endotracheal intubation •
Blood transfusion •

Patient with multiple trauma, -
:conscious Rx
a) ABC
b) I.V.F
c) Cross match

in abdominal trauma, all true -4
:except
a) spleen is the common damaged organ
b) badly injured spleen need splenectomy
c) abdominal lavage (DPL) often exclude abdominal hemorrhage
d) abdominal examination often accurate to localize the site of trauma

Blunt trauma: most frequent •
injuries are spleen (45%), liver (40%), and retroperitoneal .haematoma (15%)
Diagnostic peritoneal •
lavage :Mostly superseded by abdominal sonography for unstable patients and CT scanning in stable patients. Useful, when these are inappropriate or unavailable, for the identification of the presence of free intraperitoneal fluid (usually blood).Aspiration of blood, gastrointestinal ***s, bile, or faeces through the lavage catheter .indicates laparotomy**

:recent heamothorax.-5
a) thoracotomy and decortication
b) aspiration of chest
c) insertion of chest tube
d) volume replacement only

best treatment for tension -6

:pneumothorax & pt in distress

- a) IVF**
- b) O2**
- c) Respiratory stimulator**
- d) Aspiration of air by needle**
- e) Intubation**

the best method for temporary -7

:control of bleeding is

- a) arterial tourniquet**
- b) venous tourniquet**
- c) direct finger pressure**
- d) adrenaline**

indication of tracheostomy, all true-8

:except

- a) foreign body in larynx**
- b) LT recurrent nerve cut**
- c) CA larynx**
- d) In some procedure which involve in radiation exposure**
- e) None of the above**

Indications

The advent of the antibiotic era coupled with great advances in anesthesia have made tracheotomy or tracheostomy a commonly .performed elective procedure

To bypass obstruction

Congenital anomaly (eg, laryngeal hypoplasia, vascular web)

Foreign body that cannot be dislodged with Heimlich and basic cardiac life support (BCLS) maneuvers

Supraglottic or glottic pathologic condition (eg, infection, neoplasm, bilateral vocal cord paralysis)

Neck trauma that results in severe injury to the thyroid or cricoid cartilages, hyoid bone, or great .vessels

Subcutaneous emphysema

Appears in face, neck, or chest
Readily dissecting air, especially through inflamed or traumatized tissue planes, leading to massive soft tissue edema
Facial fractures that may lead to upper airway obstruction (eg, comminuted fractures of the midface and mandible)

Edema

Trauma

Burns

Infection

Anaphylaxis

To provide a long-term route for mechanical ventilation in cases of respiratory failure

To provide pulmonary toilet

Inadequate cough due to chronic pain or weakness

Aspiration and the inability to handle secretions (The cuffed tube allows the trachea to be sealed off from the esophagus and its refluxing ***s.**

Thus, this intervention can prevent aspiration and provide for the removal of any aspirated substances. However, some would argue that the risk of aspiration is not actually lessened, as secretions can leak around the cuffed tube and reach the lower airway.)

Prophylaxis (as in preparation for extensive head and neck procedures and the convalescent period)

Severe sleep apnea not amendable to continuous positive airway pressure (CPAP) devices or other, less invasive surgery

:length of trachea in adult is-9

a) 11-12cm

b) 24cm

- c) 20cm
- d) 4cm
- e) None of the above

the length of the trachea is 10-15 cm in adults (average 12.5 cm) and the distance from the vocal cords to the upper end of the trachea as 1 cm, three diagrams representing the cords to the carina distances (CCD) were drawn representing: 1) a short trachea (11 cm), 2) an average length trachea (13.5 cm), and 3) a long trachea (16 cm)

surgery- the most effective -10 monitoring method in pt with acute :bleeding is

- a)HB
- b) HCT
- c) Vital sign
- d) Amount of blood loss

pt sustained abdominal -11 truma,and was suspect intra-peritoneal bleeding,the most :important diagnostic test is
"a) CT scan - "if vitally stable
b) Direct peritoneal lavage DPL

A 21 year old is involved in a -12 head-on collision as the driver of a motor vehicle. He is noted to be severely tachypneic and hypotensive. His trachea is deviated to the left, with palpable subcutaneous emphysema and poor air entry in the right hemithorax. The most appropriate first treatment :procedure should be
a. Arterial puncture to measure .blood gases
.b. Stat chest x-ray

- .c. Intubation and ventilation
- d. Needle thoracocentesis or tube thoracotomy prior to any
- .investigations
- .e. Immediate tracheostomy

The respiratory distress -13
:syndrome after injury is due to

- a) pneumothorax
- b) aspiration
- c) pulmonary edema
- d) pulmonary embolus
- e) none of the above

ARDS formerly most commonly
signified adult respiratory distress
syndrome to differentiate it from
infant respiratory distress syndrome
in premature infants. However, as
this type of pulmonary edema also
occurs in children, ARDS has
gradually shifted to mean acute
.rather than adult

most commonly affected organ in -14
:abdominal blunt trauma

- a) Liver
- b) Spleen (emergency medicine recall p 41 9)
- c) Kidney
- d) Intestine

Most commonly affected organ in -
:blunt abdominal trauma is

- Liver-4
- B-Spleen
- C-Kidney
- D-Intestine

للامانة اسئلة العظام

ليست سهلة لكن ما
يميزها ان عاقل 15%
من الاسئلة بتكرر.....
دعواتكم لكل من كتب
وجمع هذه الاسئلة
ووضعها بين ايديكم
اسألكم الدعاء فأنني
مقبل علي امتحان مثلكم
جميعا
واتمن التفاعل من
الزملاء وسرد تجاربهم
بالامتحانات فكما تأخذ
لا بد ان تعطي وكما
تستفيد لابد ان تفيد
بالتوفيق للجميع